



**Texas Department of Insurance**  
**Division of Workers' Compensation**  
 Medical Fee Dispute Resolution, MS-48  
 7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

## MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

### PART I: GENERAL INFORMATION

Requestor Name and Address:  NORTH CENTRAL SURGICAL CENTER 9301 NORTH CENTRAL EXPRESSWAY STE 100 DALLAS TX 75231	MFDR Tracking #: M4-10-3037-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #:  HARTFORD FIRE INSURANCE CO Box #: 47	Date of Injury:
	Employer Name:
	Insurance Carrier #:

### PART II: REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "As we had requested in our original submission and subsequent appeal a reimbursement of 200% of the Medicare APC... Respondent has implied that since the provider billed for an implantable utilizing HCPCs code L8699, the Texas Administrative Code requires payment at 130% of the Medicare APC rate. Please be advised TAC 134.401(f)(1)(B) states and I am paraphrasing "a facility or surgical implant provider request separate reimbursement in accordance with subsection (g) of this section..." We did not request separate reimbursement for the implantable at the original time of billing and upon appeal we continued to maintain our original disposition of 200% reimbursement."

**Amount in Dispute:** \$2,882.35\*

### PART III: RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "Provider contends that they are entitled to 200% of fee schedule. However, bill contains an implant which requires the billing to be reimbursed at 130% of fee schedule."

### PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
11/03/09	CPT Codes 28725, 20900, 20680	\$4,779.13 x 200% = \$9,558.26 - \$6,635.91 (carrier payment)	\$2,882.35	\$2,882.35
<b>Total Due:</b>				\$2,882.35

### PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division rule at 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, effective for medical services provided in an outpatient acute care hospital on or after March 1, 2008, set out the reimbursement guidelines for hospital outpatient services.

This request for medical fee dispute resolution was received by the Division on March 2, 2010.

\* The requestor submitted an up-dated table on March 24, 2010.

According to the explanation of benefits, the services in dispute were paid using a contracted fee arrangement. Tex. Lab. Code Ann. §413.011(d-3) states that the division may request copies of each contract under which fees are being paid, and goes on to state that the insurance carrier may be required to pay fees in accordance with the division's fee guidelines if the contract is not provided in a timely manner to the division. On September 22, 2010 the division requested a copy of the contract between the network and the health care provider. The carrier stated in a response to the division's request that

there is no contract between an informal/voluntary network and the requestor and went on to state that the charges were discounted per review by Qmedtrix's billcheck service. For that reason, the disputed health care will be reviewed in accordance with §134.403.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason code:
  - 217 – The charges have been discounted per review by Qmedtrix's billcheck service.
  - 45 – Charge exceeds fee schedule/max allowable or contracted/legislated fee arrangement.
2. Division rule at 28 TAC §134.403(e) states, in pertinent part, that "Regardless of billed amount, reimbursement shall be:
  - (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code 413.011; or
  - (2) if no contracted fee schedule exists that complies with Labor Code 413.011, the maximum allowable reimbursement (MAR) amount under subsection (f), including any applicable outlier payment amounts and reimbursement for implantables;"
3. Pursuant to Division rule at 28 TAC §134.403(f), "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the *Federal Register*. The following minimal modifications shall be applied.
  - (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
    - (A) 200 percent; unless
    - (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent."
4. Under the Medicare Outpatient Prospective Payment System (OPPS), all services are classified into groups called Ambulatory Payment Classifications (APCs). Services in each APC are clinically similar and require similar resources. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Within each APC, payment for ancillary and supportive items and services is packaged into payment for the primary independent service. Packaged services are considered integral to the primary paid service and are not separately reimbursed. An OPPS payment status indicator is assigned to each HCPCS code. The status indicator for each HCPCS code is shown in OPPS Addendum B, and a full list of status indicators and their definitions is published in Addendum D1 of the OPPS proposed and final rules each year, both of which are publicly available from the Centers for Medicare and Medicaid services.
5. Upon review of the documentation submitted by the Requestor and Respondent, the Division finds that:
  - (1) No documentation was found to support a contractual agreement between the parties to this dispute;
  - (2) MAR can be established for these services; and
  - (3) Separate reimbursement for implantables was NOT requested by the requestor.
6. Consequently, reimbursement will be calculated in accordance with Division rule at 28 TAC §134.403(f)(1)(A) as follows:

APC	Outlier Amount	Separate reimbursement for implantables WAS NOT requested under Rule §134.403	APC X 200%	Fee Schedule (CMS x DWC conversion factor)	Less amount paid by Respondent	Additional amount due Requestor
\$4,779.13	\$0.00	\$0.00	\$9,558.26	\$0.00	06,635.91	\$2,882.35

Based upon the documentation submitted by the parties and in accordance with Texas Labor Code §413.031(c), the Division concludes that the requestor is due additional payment. As a result, the amount ordered is \$2,882.35.

**PART VI: GENERAL PAYMENT POLICIES/REFERENCES**

Texas Labor Code §413.011(a-d), §413.031 and §413.0311  
 28 Texas Administrative Code §133.305, §133.307, §134.403  
 Texas Government Code, Chapter 2001, Subchapter G

**PART VII: DIVISION DECISION**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$2,882.35 plus accrued interest per Division rule at 28 TAC §134.130 and §413.019 (if applicable), due within 30 days of receipt of this order.

**DECISION/ORDER:**

\_\_\_\_\_ March 14, 2011  
Authorized Signature Medical Fee Dispute Resolution Officer Date

**PART VIII: YOUR RIGHT TO REQUEST AN APPEAL**

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 TAC §148.3(c).

Under Texas Labor Code §413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**